

[illegible]

Preferred Pharmacy	Street Address	City	State	() Phone #
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Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		Relationship to Patient
Social Security Number	Date of Birth	Employer

Current Symptoms: _____

How did you hear about us? _____

Do you have any allergies? _____

Race:	American	Indian or Alaskan Native	Ethnicity:	Hispanic or Latino
	Asian			Not Hispanic or Latino
	Black or African			American Decline to Specify
	Native Hawaiian or Other Pacific Islander			
	White			
	Decline to Specify			

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Oculoplastic Eye Surgeons of Phoenix to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

Patient's signature

Today's date

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Oculoplastic Eye Surgeons of Phoenix.

Patient's signature

Today's date

Oculoplastic Surgeons of Phoenix offer its patients the ability to communicate with healthcare providers via electronic mail (e-mail) over the Internet.

If you have an Internet e-mail address and would like to take advantage of this service, please discuss your wishes with your healthcare provider(s) first. Some healthcare providers prefer not to communicate with their patients over the Internet.

If a healthcare provider agrees to exchange e-mail with you, please observe the following:

E-mail Rules:

1. E-mail may be used for requesting information and for asking non-urgent questions. It should not be used in emergencies. If you are experiencing a sudden or severe change in your health or otherwise need an immediate response, please call 911 or visit the nearest Emergency Department.
2. E-mail messages may not be confidential.
 - Do not use e-mail to send or request very sensitive information. Oculoplastic Surgeons of Phoenix cannot and do not guarantee the confidentiality of any messages being sent over the Internet.
 - Messages can be misdirected or intercepted by unintended parties.
 - Patients who want e-mail sent to work addresses must recognize that employers may have the right to monitor their e-mail.
 - Your healthcare provider may ask a nurse or other provider to assist with email volume or response.
 - We will not respond to communications that are considered obscene or harassing.
3. Your healthcare provider will document e-mail communications in your medical record- either by placing a copy of the message in your record, or by summarizing the message in a written note.

Sending E-mail:

Please be sure to include the following information in the body of every e-mail message that you send to your healthcare provider:

- Your full name
- Your birth date or your medical record number

If you do not provide this information, your healthcare provider may not be able to respond. In order to protect your confidentiality do not place name, date of birth or medical record number in subject line.

If a message is ever returned because of a "bad address," please make sure that you entered the complete address as it was given to you. If you are sure that you entered the address the healthcare provider provided, please call the healthcare provider's office to verify you have the correct address and that the e-mail system is functioning properly.

If your healthcare provider does not answer your e-mail in what you consider to be reasonable period of time, please call his or her office. Your healthcare provider may be out of the office or we could be experiencing a technical problem and unable to respond to e-mail. We cannot guarantee a particular response time.

I agree to not use or forward my health care provider's e-mail for purposes other than communication with me about my health care.

I understand and agree to the terms outlined in this document.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, relationship to Patient

Signature of Witness

Oculoplastic Eye Surgeons of Phoenix

Name	Ht:	Wt:	Age:
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MEDICAL HISTORY Have you had, or do you currently have any of the following?

Ocular:

Dry Eye ☐ Yes ☐ No

Cataracts ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

Macular Degeneration ☐ Yes ☐ No

Retinal Detachment ☐ Yes ☐ No

Cardiovascular:

Heart Surgery ☐ Yes ☐ No

Heart Attack ☐ Yes ☐ No

Chest Pain ☐ Yes ☐ No

Heart disease ☐ Yes ☐ No

Abnormal Rhythm ☐ Yes ☐ No

Pacemaker or Defibrillator ☐ Yes ☐ No

Rate set at _____

High Blood Pressure ☐ Yes ☐ No

Congestive Heart Failure ☐ Yes ☐ No

Do you Exercise? ☐ Yes ☐ No

If "Yes", what and how often? _____

Lung:

Asthma ☐ Yes ☐ No

Bronchitis ☐ Yes ☐ No

Emphysema/COPD ☐ Yes ☐ No

Pneumonia ☐ Yes ☐ No

Shortness of Breath ☐ Yes ☐ No

If yes, when? _____

Social History:

Do you Smoke? ☐ Yes ☐ No

Pack/Day _____ Years? _____

Do you consume alcohol? ☐ Yes ☐ No

How much? _____ How often? _____

Recreational drug use? ☐ Yes ☐ No

Name of drug? _____

Other:

Sensitive to Iodine/tape/latex? ☐ Yes ☐ No

IF "Yes" do you get skin rash or hives? _____

Wheezing or trouble breathing? ☐ Yes ☐ No

Any problems with anesthesia? ☐ Yes ☐ No

What? _____

Systemic:

Kidney Problems ☐ Yes ☐ No

Liver Problem of Cirrhosis ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Acid Reflux or GERD ☐ Yes ☐ No

Endocrine:

Diabetes ☐ Yes ☐ No

Thyroid ☐ Yes ☐ No

Blood Disease ☐ Yes ☐ No

If "Yes", What? _____

Arthritis ☐ Yes ☐ No

Autoimmune Disorder ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

If "Yes" what Type? _____

Neurological:

TIA, When? _____ ☐ Yes ☐ No

Stroke, When? _____ ☐ Yes ☐ No

Seizures, When _____ ☐ Yes ☐ No

Sleep Apnea ☐ Yes ☐ No

Past Eye Surgeries: List all eye surgeries and dates.

Past surgeries: List all other past surgeries and dates.

Medications: List all Medications

Allergies: List all allergies. If you have no allergies, write "None".

Is there anything else we should know about?

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

Name of Person/Organization Releasing Information

Address City / State / Zip

Phone Number // Fax Number

To Release my Information To:

Oculoplastic Eye Surgeons of Phoenix

Name of Person/Organization Receiving Information

4045 E Unions Hills Dr. Ste 115, Phoenix, AZ 85050

Address City / State / Zip

623-522-8687// Fax 623-522-8683

Phone Number // Fax Number

INFORMATION TO BE RELEASED:

Complete Medical Record

Medical Records for Specific Dates of Service (please list) from _____ to _____

Other (please list) _____

This authorization will remain in effect for one year from the signed date below.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X _____
Printed Name of Patient or Personal Representative

X _____
Signature of Patient or Personal Representative DATE

Description of Personal Representative's Authority (attach necessary documentation)

Date Sent: _____ By: _____ Via: _____



FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients, as opposed to **routine eye exams**. We do not participate with **ANY** vision plans (VSP/Davis Vision, etc.). **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

A refractive examination is not a covered service by most insurance companies, including Medicare. We do not offer refractive examinations at our practice.

It is the patient's/parent's/guardian's responsibility to:

1. Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
2. Bring all of your current insurance cards to all visits.
3. Provide our office with current information including address, phone numbers and employer.
4. In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. We accept cash, checks, GreenSky, Care Credit, and all major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a **\$50.00** returned check fee.

Any patient who cancels a scheduled, elective surgery without giving more than thirty (30) business days notice prior to surgery, will be charged a cancellation fee of **\$150.00**. Any patient who cancels a scheduled, elective surgery without giving more than fourteen (14) business days notice prior to surgery, or does not show up for surgery, will be charged a cancellation fee of **\$250.00**. Legitimate emergencies will be taken into consideration.



For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

It is Oculoplastic Eye Surgeons of Phoenix's policy to only accept payment plans as a last resort. We offer financing through our partners GreenSky and Care Credit. Prior to filling out our Economic Hardship Application, you must present a declined application from either GreenSky or Care Credit. If you do not qualify for financing, you can fill out our Economic Hardship Application and provide documents according to our Financial Assistance Policy.

I have read and understand the above financial policy.

Signature of patient/guardian/parent

Date

Printed name of patient

Date



Authorization for Use and Disclosure of Protected Health Information

Oculoplastic Eye Surgeons of Phoenix, P.L.C. (the "**Practice**")

Authorization:

By my signature below, I affirm, as a patient of the Practice named above OR as the parent or legal guardian of a minor child that is a patient of the Practice named above (the "**Patient**"), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the "**Images**"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's name; (iii) to publicize the fact that medical services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice (collectively referred to herein as the "**Information**"); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites.

I understand that once my photographs or images become part of a motion picture, videotape, video disc, or other electronic recording that I will not be able to revoke this authorization and that they will become a permanent part of the Oculoplastic Eye Surgeons of Phoenix website which includes, but is not limited to www.eyelidsphoenix.com. Oculoplastic Eye Surgeons of Phoenix cannot retract broadcasting or other disclosures that have already occurred.

Additional Information

The purpose of this authorization is to permit the Information, including Images, to be used for marketing of the Practice, and I explicitly consent to the use of Information for advertising and marketing activities to promote the Practice on social media. I acknowledge and agree that no compensation will be provided for the use of the Information.

I understand that I am under no obligation to participate in the Program and am not required to sign this form. I further understand that Oculoplastic Eye Surgeons of Phoenix may not condition my treatment, payment, or enrollment, or eligibility for benefits based on whether I sign this Authorization.

I release Oculoplastic Eye Surgeons of Phoenix, its agents, employees, licensees, and assigns from and against any and all claims and liability which I have or may have against Oculoplastic Eye Surgeons of Phoenix for disclosure of confidential information, invasion of privacy, defamation, or any other cause of action arising out of production, distribution, broadcast, or exhibition of my photographs.

If Patient is signing on his or her own behalf, this authorization expires when the Patient informs the Practice that he or she is no longer a patient of the Practice. If Patient is signing on behalf of a minor child, this authorization expires when the Patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at



any time by notifying the Practice in writing, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all re-disclosure of information.

I fully understand and accept the terms of this Authorization. I have read this Authorization and understand what information may will be used and disclosed, who may use and disclose the information, and the recipient(s) of that information. I acknowledge Oculoplastic Eye Surgeons of Phoenix has answered all my questions to my satisfaction and that I am entitled to receive a copy of this Authorization.

Signature of Patient/Legal Representative

Date

Witness

Date